EXHIBIT B

NFL CONCUSSION SETTLEMENT

IN RE: NATIONAL FOOTBALL LEAGUE PLAYERS' CONCUSSION INJURY LITIGATION

No. 2:12-md-02323 (E.D. Pa.)

BASELINE ASSESSMENT PROGRAM HIPAA AUTHORIZATION FORM

You must complete and sign this Form if you are a **Retired NFL Football Player** or the **Representative Claimant** of a Retired NFL Football Player and want to participate in the Baseline Assessment Program (the "BAP"). This Form authorizes the use and disclosure of "Protected Health Information" as that term is defined in 45 C.F.R. § 160.103, relating to your participation in the BAP. Protected Health Information includes, but is not limited to, information regarding the Retired NFL Football Player's medical care, treatment, physical or mental condition, and medical expenses.

Complete and sign this Authorization and submit it to the BAP Administrator.

The capitalized terms not defined in this form are defined in the Settlement Agreement, which is available at www.nflconcussionsettlement.com or by calling toll free (855) 887-3485.

You should retain a copy of all materials submitted to the BAP Administrator.

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I. RETIRED NFL FOOTBALL PLAYER INFORMATION

Settlement Program ID	|___|___|___|___|___|___|___|___|___|___|			
Retired NFL Football Player Name	First	M.I.	Last	Suffix
Social Security Number, Taxpayer ID or Foreign ID Number (if Retired NFL Football Player is not a U.S. Citizen) **of Retired NFL Football Player** (if known)	|___|___|___| - |___|___| - |___|___|___|___| or |___|___|___|___|___|___|___|___|___|___|	**Date of Birth of Retired NFL Football Player**	_____/_____/_____ (Month/Day/Year)	

II. PARTIES AUTHORIZED TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

By signing and submitting this Form, I authorize the use and disclosure of all Protected Health Information regarding my (or the Retired NFL Football Player's, if signed by a Representative Claimant) medical care, treatment, physical or mental condition, and medical expenses by the Claims Administrator, Special Master, BAP Administrator, Lien Resolution Administrator, Qualified BAP Providers, Qualified BAP Pharmacy Vendors, Qualified MAF Physicians, Appeals Advisory Panel members, Appeals Advisory Panel Consultants, the Court, Class Counsel, Counsel for the NFL Parties, and the NFL Parties (which, in turn, may share Protected Health Information with the NFL Parties' insurers or reinsurers) in the performance of their functions and duties relating to the BAP under the Settlement Agreement.

III. AUTHORIZATION

By signing below, I acknowledge and understand all of the following:

1.	I have the right to revoke this authorization at any time. If I wish to revoke the authorization, I must do so in writing and must provide my written revocation to the BAP Administrator. The written revocation must be signed and dated. The revocation will not apply to any disclosures that already have been made in reliance on this authorization prior to the date upon which the BAP Administrator receives my written revocation.
2.	My authorization of the disclosure of the subject Retired NFL Football Player's Protected Health Information is voluntary, which means I can refuse to sign this Form. I do not need to sign this Form to obtain health treatment from any medical provider or to enroll in or be eligible for any health plan benefits. However, I recognize that if I do not sign this Form and submit it to the BAP Administrator, the BAP Administrator may be unable to process the results of my baseline assessment examination for the purposes set forth in the Settlement Agreement and may be unable to provide the information that certain third parties, such as the Claims Administrator, need to process a potential claim for a Monetary Award or BAP Supplemental Benefits, or otherwise perform their rights and obligations under the Settlement Agreement.

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3.	Any Protected Health Information or other information released to the Claims Administrator, Special Master, BAP Administrator, Lien Resolution Administrator, Qualified BAP Providers, Qualified BAP Pharmacy Vendors, Qualified MAF Physicians, Appeals Advisory Panel members, Appeals Advisory Panel Consultants, the Court, Class Counsel, Counsel for the NFL Parties, and the NFL Parties (including the NFL Parties' insurers or reinsurers) may be subject to re-disclosure by such person/entity, and may no longer be protected by applicable federal and state privacy laws. Each of those persons and entities, however, is permitted to use and disclose your information only in accordance with this Form, the Settlement Agreement, a contract executed pursuant to the Settlement Agreement, orders of the Court, and/or applicable law.
4.	My Protected Health Information may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome ("AIDS"), or human immunodeficiency virus ("HIV"), behavioral or mental health services and treatment for alcohol and drug abuse.
5.	This Form is valid from the date of my signature in Section V and expires on December 31, 2032.
6.	I have a right to receive and retain a copy of this Form.
7.	Any photostatic copy of this Form shall have the same authority as the original, and may be substituted in its place.

IV. CONSENT TO PARTICIPATE IN RESEARCH

☐	By checking this box, the Retired NFL Football Player elects to provide his medical records (and, as such, his Protected Health Information) for use in connection with medical research into cognitive impairment and safety and injury prevention with respect to football players pursuant to Section 5.10(a) of the Settlement Agreement. Any personally identifying information concerning the Retired NFL Football Player will be redacted from medical records or information provided pursuant to this consent in accordance with the standards set forth in 45 C.F.R. § 164.514(a)-(b).

V. SIGNATURE

The Retired NFL Football Player or Representative Claimant of the Retired NFL Football Player named in Section I must sign and date this Form below. **By signing below, I declare under penalty of perjury, pursuant to 28 U.S.C. § 1746, that all information provided in this HIPAA Authorization Form is true and correct to the best of my knowledge, information and belief.**

Signature			**Date**	__/__/____ (Month/Day/Year)
Printed Name	First	M.I.	Last	Suffix
If you are signing this Form as a Representative Claimant, describe your relationship to the Retired NFL Football Player and your authority to act on his behalf:				

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VI. HOW TO SUBMIT THIS FORM	
You may submit this Form in one of two ways:	
By U.S. Mail	NFL Class Action Settlement BAP Administrator 600 Vine St., Suite 2006 Cincinnati, OH 45202
By Delivery	NFL Class Action Settlement BAP Administrator 600 Vine St., Suite 2006 Cincinnati, OH 45202